SERFF Tracking Number:	*AMFT-127170845*	*State:*	*Arkansas*
Filing Company:	*Monitor Life Insurance Company of New York*	*State Tracking Number:*	*48786*
Company Tracking Number:	*ML-SLIFE-ENRFORM (3-11)*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Supplemental Application Filing fpr Group Term Life*		
Project Name/Number:	*Supplemental Application Filing for Group Term Life/ML-SLIFE-EnrForm (03-11)*		

Filing at a Glance

Company: Monitor Life Insurance Company of New York

Product Name: Supplemental Application Filing fpr Group Term Life	SERFF Tr Num: AMFT-127170845	State: Arkansas
TOI: L04G Group Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 48786
Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium	Co Tr Num: ML-SLIFE-ENRFORM (3-11)	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Rebecca Ewing	Disposition Date: 05/18/2011
	Date Submitted: 05/16/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Supplemental Application Filing for Group Term Life	Status of Filing in Domicile: Pending
Project Number: ML-SLIFE-EnrForm (03-11)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 05/18/2011	
State Status Changed: 05/18/2011	Deemer Date:
Created By: Rebecca Ewing	Submitted By: Rebecca Ewing

Corresponding Filing Tracking Number:

Filing Description:

Supplemental Application Filing for Group Term Life

Please find attached the following form for your review and approval:

ML-SLIFE-EnrForm (3-11)

SERFF Tracking Number:	*AMFT-127170845*	*State:*	*Arkansas*
Filing Company:	*Monitor Life Insurance Company of New York*	*State Tracking Number:*	*48786*
Company Tracking Number:	*ML-SLIFE-ENRFORM (3-11)*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Supplemental Application Filing fpr Group Term Life*		
Project Name/Number:	*Supplemental Application Filing for Group Term Life/ML-SLIFE-EnrForm (03-11)*		

This is a supplemental change/application form to be used with Group Term Life Insurance Policy, form number ML-GTLP
(11/09), which was approved by your Department on January 24, 2011.

Thank you for your review of this filing. Please feel free to contact me if you have any questions or comments.

Sincerely,
Rebecca Ewing, FLMI, HIA, ACS, ACP
Compliance Consultant
Lewis & Ellis, Inc.

Company and Contact

Filing Contact Information

Rebecca Ewing, Compliance Consultant	rewing@lewisellis.com
2929 N. Central Expy., Suite 201	972-850-3272 [Phone]
P. O. Box 851857	972-850-3273 [FAX]
Richardson, TX 75085	

Filing Company Information

Monitor Life Insurance Company of New York	CoCode: 81442	State of Domicile: New York
70 Genesee Street	Group Code:	Company Type: Insurance Company
Utica, NY 13502-3502	Group Name:	State ID Number:
(800) 422-6200 ext. 342[Phone]	FEIN Number: 16-0986348	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monitor Life Insurance Company of New York	$50.00	05/16/2011	47648613

SERFF Tracking Number:	*AMFT-127170845*	*State:*	*Arkansas*
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Project Name/Number:	*Supplemental Application Filing for Group Term Life/ML-SLIFE-EnrForm (03-11)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/18/2011	05/18/2011

SERFF Tracking Number:	*AMFT-127170845*	*State:*	*Arkansas*
Filing Company:	*Monitor Life Insurance Company of New York*	*State Tracking Number:*	*48786*
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Project Name/Number:	*Supplemental Application Filing for Group Term Life/ML-SLIFE-EnrForm (03-11)*		

Disposition

Disposition Date: 05/18/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFT-127170845*	*State:*	*Arkansas*
Filing Company:	*Monitor Life Insurance Company of New York*	*State Tracking Number:*	*48786*
Company Tracking Number:	*ML-SLIFE-ENRFORM (3-11)*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Supplemental Application Filing fpr Group Term Life*		
Project Name/Number:	*Supplemental Application Filing for Group Term Life/ML-SLIFE-EnrForm (03-11)*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Third Party Authorization		Yes
Form	Supplemental Life Enrollment/Change form		Yes

SERFF Tracking Number:	*AMFT-127170845*	*State:*	*Arkansas*
Filing Company:	*Monitor Life Insurance Company of New York*	*State Tracking Number:*	*48786*
Company Tracking Number:	*ML-SLIFE-ENRFORM (3-11)*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Supplemental Application Filing fpr Group Term Life*		
Project Name/Number:	*Supplemental Application Filing for Group Term Life/ML-SLIFE-EnrForm (03-11)*		

Form Schedule

Lead Form Number: ML-SLIFE-EnrForm (3-11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ML-SLIFE-EnrForm (3-11)	Application/ Enrollment Form	Supplemental Life Enrollment/Change form	Initial		61.800	ML-SLIFE-EnrForm (03-11).pdf

Monitor Life Insurance Company of New York

5722 I-55 North Frontage Road, Jackson, Mississippi 39211, Telephone 601-956-2028

Life Enrollment/Change Form

*Denotes required fields for enrollment. For items with ** please select a Reason for Enrollment **OR** Change.

EMPLOYER INFORMATION: To Be Completed By Employer

Company Name: _____ *Group No.:_____

Date Employed Full Time: _____ *Effective Date of Coverage or Change _____

Class # _____ **REASON FOR ENROLLMENT OR CHANGE**

ENROLL
- ○ Open Enrollment
- ○ New Group
- ○ New Hire
- ○ COBRA
- ○ Add Dependent
- ○ Group Request
- ○ Member Request
- ○ Qualifying Event (Reason)
- ○ Date: _____/_____/_____
- **List Reason: _____

TERMINATE COVERAGE
- ○ Terminate Subscriber
- ○ Terminate Dependent
- ○ Deceased
- ○ Termination Reason: _____

CHANGE
- ○ Name
- ○ Address/Phone

EMPLOYEE STATUS:

○ Active ○ COBRA ○ Salary ○ Hourly ○ Number of hours a week _____ ○ Other _____

Benefits Administrator Approval: Date:

EMPLOYEE LIFE INSURANCE ELECTIONS[1]

I elect the following Life Insurance options for myself: ☐ Basic employee group term life coverage
Indicate dollar amount $ _____ salary multiple _____

Supplemental Employee Life Insurance Elections: ☐ Accidental Death and Dismemberment coverage (if offered)

☐ Employee supplemental term life insurance (if offered): Indicate dollar amount $_____ salary multiple _____
If you are requesting a total coverage amount in excess of the guaranteed issue amount, you may be required to submit evidence of insurability.

Dependent Life Insurance Elections (if offered):
From the options your employer has chosen to offer, please indicate your elections for your eligible dependents

Spouse term life coverage amount $ _____; Child term life coverage amount $ _____
☐ Dependent Accidental Death and Dismemberment coverage

Type of Coverage : ☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Employee/Children ☐ Employee/Spouse/Child(ren)

Beneficiary Information The Beneficiary(ies) you list below will apply to your Life and Accidental Death and Dismemberment benefits (if offered). Your beneficiary may be anyone you choose, and you may name more than one beneficiary. When more than one beneficiary is designated, payment will be made in equal shares, unless designated otherwise, to each surviving beneficiary, or the entire amount will be paid to the last survivor. Total percentage of beneficiary allocation must equal 100% and be in whole percentage points

*Name	*Address	*Relationship	*Percentage Allocated

Below are the questions that must be answered for all person proposed for supplement group term life coverage.

1. Have you or anyone to be covered used any tobacco product within the past 5 years? Yes____No____

2. Is the main person proposed for coverage Actively at Work on a full-time at his/her normal place of employment?

   Yes___No ___

3. Is any proposed dependent hospital confined and/or disabled (i.e. unable to perform normal daily functions)?

   Yes___No___

4. In the past 5 years, have you or anyone proposed for coverage been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex?

   Yes___No ___

5. Has any person proposed for coverage had in the past 5 years: cancer or any malignancy which includes carcinoma (other than basil cell carcinoma skin cancer), sarcoma, Hodgkin's disease, leukemia, lymphoma, malignant tumor, cirrhosis, hepatitis B or C, blood disorder, emphysema, or chronic obstructive pulmonary disease (COPD)? Yes___No___

6. Has any person proposed for coverage had or been diagnosed within the last 5 years: heart attack, heart disease, heart surgery, congestive heart failure, angina or prescribed nitroglycerin, any other abnormality of the heart (other than high blood pressure) including coronary artery disease, peripheral vascular disease, stroke, transient ischemic attack, or any other cerebrovascular disease, any abnormal kidney function, kidney disease, renal failure or insufficiency, required dialysis, spina bifida, lupus, diabetes, or sickle cell anemia? Yes___No___

7. Has any person proposed for coverage had in the last 5 years: Epilepsy, Seizure, Paralysis of any kind, Alzheimer's Disease, Dementia, any degenerative neurological disorder, Multiple Sclerosis, Cerebral Palsy, Lou Gehrig's disease, Cystic Fibrosis, Parkinson's disease, Hemophilia, or Schizophrenia? Yes____No___

Any person proposed for coverage who answers yes to any question from number 3 through number 7 is not eligible for supplemental group term life under this policy.

Name_____ DOB _____ Height_____ Weight ____ Gender___

Name_____ DOB _____ Height_____ Weight ____ Gender___

Name_____ DOB _____ Height_____ Weight ____ Gender___

Name_____ DOB _____ Height_____ Weight ____ Gender___

Name_____ DOB _____ Height_____ Weight ____ Gender___

Name_____ DOB _____ Height_____ Weight ____ Gender___

Name_____ DOB _____ Height_____ Weight ____ Gender___

Name_____ DOB _____ Height_____ Weight ____ Gender___

All proposed insureds must meet the height and weight guide for coverage.
Height and Weight guide is attached to this application

LIFE WAIVER (complete only if waiving coverage)

I understand that if I decide to apply for life coverage for myself and any applicable dependent(s) at a later date, neither my dependent(s) will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI

· Waive Life · Myself □ · Spouse · Dependent(s) **Reason**: · Other Insurance □ · Spousal Coverage □

· Other Reason (please explain):

Employee Signature (only if you are waiving coverage) _____ Date_____

EMPLOYEE INFORMATION

*Last Name_____ *First Name_____ MI_____

*Gender(M/F) ____ *Birth date _____ *Social Security Number _____

*Address_____

*City _____ *State_____*Zip Code_____

Work Phone _____ Home Phone_____

FAMILY MEMBERS TO BE COVERED OR DELETED

If address and phone numbers of covered dependents are different from those of employee, please attach that information on a separate sheet of paper

	FULL NAME (Last, First MI)	SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER
☐ Enroll ☐ Delete		M F	Spouse	/ /	
☐ Enroll ☐ Delete		M F		/ /	
☐ Enroll ☐ Delete		M F		/ /	
☐ Enroll ☐ Delete		M F		/ /	
☐ Enroll ☐ Delete		M F		/ /	
☐ Enroll ☐ Delete		M F		/ /	
☐ Enroll ☐ Delete		M F		/ /	
☐ Enroll ☐ Delete		M F		/ /	

EMPLOYEE SIGNATURE

[1]Life insurance products are underwritten by Monitor Life Insurance Company of New York

Fraud Notice

Arkansas Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Florida Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Ohio Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony

Oklahoma Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

General Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application.

_____ _____

Employee Signature Date

SERFF Tracking Number:	*AMFT-127170845*	*State:*	*Arkansas*
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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

ML-GrpLifeSuppApp-Readability.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Please see Forms Schedule Tab for application form.

Item Status: **Status Date:**

Satisfied - Item: Third Party Authorization

Comments:

Attachment:

ML-Lewis&Ellis Authorization letter (04-14-2011).pdf

May 16, 2011

Re: Readability Certification for Policy Forms
Monitor Life Insurance Company of New York

To Whom It May Concern:

The following forms have been tested for readability and meet the minimum reading ease score as required by this state.

Form Number	**Flesch Score**
ML-SLIFE-EnrForm (03-11)	61.8

Rebecca Ewing

_____

Rebecca Ewing, FLMI, HIA ACS, ACP
Compliance Consultant
Lewis & Ellis, Inc. – Actuaries & Consultants

MONITOR LIFE
INSURANCE COMPANY OF NEW YORK

April 14, 2011

To: All State Insurance Department Personnel

RE: Premium Saver and Dental Insurance Policies
Monitor Life Insurance Company of New York

Monitor Life Insurance Company of New York (Monitor) authorizes Lewis & Ellis, Inc. to submit the above captioned forms on Monitor's behalf. Under this authorization, Lewis & Ellis, Inc. has the authority to:

Represent Monitor in the submission and negotiation of approval of the above forms and related rates

Give assurances and make commitments on behalf of Monitor regarding specific condition of the approval of the above referenced forms and related rates.

However, no authority is granted with permits Lewis & Ellis, Inc. to withdraw or modify any existing forms on file with your department.

Subject to the foregoing, the signature of:

Cabe Chadick, FSA, MAAA
Senior Vice President & Principal

Rebecca Ewing
Compliance Consultant

Brian Stentz
Actuarial Associate

When affixed to a letter or certification of intent, will be as binding as if signed by an officer of Monitor Life Insurance Company of New York.

Sincerely,

David R. White
President